State of New Jersey
Department of Children and Families

Psychotropic Medication Log Sheet

Child's Name: ______________________ Month/Year: _____/_____

Foster Parent's Name: ______________________

Child is assessed by a physician or a psychiatrist to determine possible risks/side effects of the medication prior to its administration. ☐ **Yes**

Day of month			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
Name of medication:	Possible Side Effects:	Tiime given:																
			16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		Tiime given:																

Side effects which are identified in the physician's/psychiatrist's assessment are immediately reported to the Division case manager and the prescribing physician. ☐ **Yes**

Physician's Review

Child's Status: ______________________

Behavior: ______________________

Well-being: ______________________

Progress: ______________________

Reason for continuing medication: ______________________

Next Appointment Date: ______________________

____
Physician's Signature

Revised: 4/1/99